| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 010682 | A. BUILDING: _____ B. WING _____ | 06/18/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE MARION | 2452 W KEM RD MARION, IN 46952 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| R 000 | INITIAL COMMENTS<br><br>This survey was for a State Residential Licensure Survey.<br><br>Survey dates: June 17, 18, 2015.<br><br>Facility number: 010682<br>Provider number: 010682<br>AIM number: N/A<br><br>Cenus bed type:<br>Residential: 45<br>Total: 45<br><br>Census payor type:<br>Medicaid: 9<br>Other: 36<br>Total: 45<br><br>Sample: 7<br><br>Brookdale Marion was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. | R 000 | | |